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THE UTILITY OF THE PSYCHIATRIC OUT-PATIENT CLINIC.*

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HISTORICAL.

IT is usual to open a paper with a historical survey of the subject under review. In a sense that is an academic approach. This paper, however, deals with the purely utilitarian aspect of psychiatric out-patient clinics; and a historical survey would only be in place if it were to give us practical suggestions, likely to prove of value in present circumstances. Up to the present time most of the literature of this subject has been in the shape of formal annual reports. A notable exception to this general statement was the paper on "The Oxford Clinic," communicated by Dr. Good at the Annual Meeting of this Association in 1921. That paper was not only an account of the general method of working a clinic, but was a concise description of how psychiatric out-patients should be handled. It was followed in 1922 by a paper by Dr. Ninian Bruce, dealing more particularly with Ministry of Pensions Clinics, and expressing the view that the methods employed there could be satisfactorily adapted for civilian patients. It is interesting to note that Dr. Ninian Bruce used the future tense in describing the utility of these clinics, and that practically all of his forecasts either have come, or are coming, true. The methods described by these writers have been widely used in many clinics in the ten years

* A paper read at the Quarterly Meeting held in London, February 25, 1931.

which have since passed; various practical points have cropped up; legislation has been changed; and a review of the utility of the psychiatric out-patient clinic in the light of these things is the aim of the present paper.

Statistics, naturally, must form the basis of any assessment of utility; but this contribution aims rather at being an informal statement of the results of practical experience in such clinics. It is an attempt to place on record the numerous small but important points which cannot quite be gleaned from the more formal type of report; and it is based on the personal study of some five hundred cases. There is, however, one other matter relating to the history of out-patient clinics to which I should like to refer. It is the work of the late Dr. Henry Rayner (1). As far as I can ascertain, Rayner was the pioneer of the psychiatric out-patient clinic in this country. About 1889, or thereby, whilst holding the post of Lecturer in Mental Diseases at St. Thomas's Hospital, he persuaded the Governors to open an out-patient department for early mental cases. He made public the results of his experience at the B.M.A. meeting at Newcastle in 1893, in a paper entitled "Remarks on the Out-Patient Department for Mental Diseases at St. Thomas's Hospital." A paragraph from that paper is worthy of quotation because it summarizes what are still the aims of the psychiatric clinic. It reads as follows:

"The direct work of the out-patient department is not only to treat the cases suitable for treatment, but to relegate into the proper channels those requiring change of air, hospital, infirmary or asylum care. The indirect advantages are the removal from the popular mind of the idea that mental disease is something apart from all other diseases, and the bringing of the alienist physician into more continual contact with the rest of the profession, thereby breaking down the isolation of alienism which has hitherto existed."

That was forty years ago. At the present time, when we look so much to America and to the Continent for guidance in the care of the early case, we should not forget that the fundamentally sound work of one of our own countrymen preceded the development of many, if not most, of the foreign clinics which are now regarded as so progressive.

The Present Position.

The passing of the Mental Treatment Act brings the subject of psychiatric out-patient clinics into sharp focus at the present time,

because statutory powers are given to local authorities to open such clinics for the management of early cases. There are two types of psychiatric clinic already established in this country. Firstly, there is the psychiatric institute type, where a whole building is devoted to the in-patient and out-patient class of early psychiatric cases—such hospitals as the Maudsley Hospital and the Jordanburn Nerve Hospital, and a few similar institutions. Secondly, there is the psychiatric out-patient department or clinic at a general hospital, which, if one excepts some of the London hospitals, is usually managed and conducted by psychiatrists belonging to the staff of a neighbouring mental hospital.

In the present discussion we are not concerned with the psychiatric institute type of clinic. Its problems are peculiar, and have already been discussed at length (2). Most people who have had dealings with early mental illnesses will agree that the psychiatric institute is the best means of providing for such cases. It will be a long time, however, before such hospitals can be erected in sufficient numbers to provide a nation-wide psychiatric service of this type.

Until such an ideal is achieved we must be content, for the majority of cases, with the second type of psychiatric clinic—that is, a department of a general hospital, managed by visiting psychiatrists and dealing almost exclusively with out-patients. One of the first things that strikes one in regard to this type of clinic is the comparatively small number of new cases seen each year. The clinics at Glasgow and Cardiff, for example, each tapping a large industrial population of between one and two millions, only receive 100 to 120 new cases annually. This certainly does not mean that the incidence of early mental illness is low. It probably means that the public and the family practitioners have not yet fully appreciated that a consulting psychiatric service is at their doorstep. There is, however, a slight but steady annual increase of new cases, which shows, that this fact is becoming more widely known. Again, there is no doubt that a large number of early cases are sent direct to Poor-Law observation wards, when they might instead have come to the psychiatric clinic.

These views are supported when one considers that in Boston, Mass., where there is a less fatalistic attitude towards mental illness than there is in this country, an annual influx of 4,000 new cases reaches the psychopathic hospital; and that institution is only one of several tapping a population which is certainly no greater than those already mentioned.

Methods of Management.

It is found, as a matter of experience, that in order to deal with a hundred new cases annually, a staff of three psychiatrists meeting once weekly for two to three hours is desirable. In addition, a nurse and a trained and experienced social worker should be available. The scheme which we have found most satisfactory at Cardiff is as follows: The medical superintendent of the mental hospital is the senior consultant at the out-patient clinic at the Cardiff Royal Infirmary. His assistants are the medical officers in charge of the male and female sides respectively of the mental hospital; one of these is a medical woman. I would draw particular attention to this arrangement. It means that if a patient attending the clinic has to go into the mental hospital, he is still under the direct care of the same medical officer—a fact which is much appreciated by patients, because it helps to dispel the strangeness which they naturally feel on first being admitted to hospital. Similarly, cases discharged from the mental hospital can attend at the clinic under the surveillance of the medical officer who cared for them during the acute stage of their illness. The nurse at the clinic is a trained mental nurse supplied by the mental hospital. Her duties are to some extent clerical. She sees that the indexing of cases, records of visits, etc., are properly done, and she is a necessity in the examination of unattended female patients.

The social worker is fully trained, and being a member of the local League of Social Service is in intimate touch with the general and personal conditions of life of our patients. Her duties are to check material facts in a patient's history, to report on the nature of the home conditions; to see that instructions regarding home treatment are carried out, and to encourage regular attendance at the clinic on the part of patients who are apt to drift and lose touch.

She is in touch with most of the official and semi-official rest homes, charitable organizations and so on, and is in a position to secure the services of those institutions should the physicians consider it necessary.

Although we find that we only use social service in about 25% of our cases, it is so essential in these that we should be practically helpless without it.

The accommodation at the clinic consists of three rooms. These are occupied separately by the psychiatrists in attendance, so that patients can receive individual and private attention. This

is not so essential for the first visit of the patient, but may become so at future attendances, when more intimate matters fall to be discussed. Thus, there is rarely any objection to students being present when a case is seen for the first time.

Individual Treatment.

A new case arriving at the clinic is seen in the first instance by the senior psychiatrist, who makes a preliminary survey of the case. This takes the greater part of an hour at least.

It may or may not be possible to make a diagnosis at this first sitting. If there is reason to suspect the presence of organic disease and the mental symptoms are not grossly developed, the patient may be admitted to the wards of the general hospital for further investigation.

This procedure is followed in early cases of general paralysis, psychoses with arterio-sclerosis or other diseases affecting the central nervous system. Reports on the cerebro-spinal fluid, blood state or other relevant matters are forwarded to the senior psychiatrist, who then makes arrangements for treatment to be carried out at an appropriate place. It may be that the patient remains where he is for treatment, and in this way we have had malaria administered to a number of very early general paralytics at the general hospital. These organic cases are few in number, however, being only about 5% of all our cases.

In a considerable number of cases the diagnosis is all too obvious —fully developed examples of schizophrenia, mental deficiency, epilepsy with psychosis, and so forth. The percentage of these gross cases fluctuates considerably from year to year, but average about 25%.

In many of them, of course, the family practitioner is fully aware of the diagnosis before he sends the case to the clinic, and he knows quite well that certification will probably be advised. It is our experience that these cases generally belong to a class which is peculiarly difficult for the general practitioner to handle. Their relatives are often difficult, and tend to pooh-pooh the family doctor's suggestion that the patient is mentally ill. The result of this is that the doctor is very reluctant to suggest even observational care, let alone certification, and it is only when he is backed up by independent expert opinion that he feels justified in pressing his views upon a completely uncomprehending relative. Many people hold the view that such cases should not be sent to a psychiatric clinic

at all—that it is a waste of time, as they cannot be treated there. Personally I entirely disagree with that view-point, and I feel that even by a single consultation and expression of opinion in such cases, the psychiatric clinic can render a very real service to the general practitioner, his patient, and the relatives.

Having cleared the ground by dealing with the more advanced cases first, let us now consider those whose mental illness takes a less pronounced form, and who, therefore, are in a position to attend the clinic regularly for treatment—such cases as anxiety states, neurasthenia, hysteria, early depression, behaviour problems and so forth. These constitute the greater part of our patients, amounting to something between 60% and 70% of all new cases.

After a case of this group has been seen by the senior psychiatrist, the patient is handed over to one of the assistants. Patients are always managed by a psychiatrist of their own sex, because we depend a good deal on psycho-therapy, and we find that better results are obtained by adhering to this plan. We have tried it the other way.

Forms of Therapy.

In considering forms of therapy, one must insist upon the importance of the modern dynamic conception of mental illness.

It is of little help to us to regard the conditions before us only from the point of view of disease entities. We are dealing with individuals, with peculiarly personal hopes, fears, beliefs and upbringings, who have met with some great obstructions in the path of their lives.

These obstructions may be organic diseases, psychological conflicts or traumata, or difficult social situations. Setting apart special forms of physical treatment, such as malaria, surgical operation and so on where indicated, we find that the major forms of therapy at our disposal are psycho-therapy and social service.

Psychotherapy.

We do not adhere to any one particular school, and we do not pretend to practise any psycho-analytical forms of therapy. Our psychotherapy, in the main, approaches most closely to the "persuasionist" doctrines of Déjerine, but we seek to incorporate in it the

teachings of any school which we find useful for the individual case. Our patients are not as a rule of a deeply thoughtful or highly intellectual status, and our psychotherapy must of necessity be of the common-sense variety rather than the academic. It varies from the "pat-on-the-back" type of suggestion to the explanation of simple mental mechanisms.

The following case will illustrate what is meant: A clerk, æt. 42, came to the clinic complaining of depression, inability to do his work, sleeplessness and anxiety attacks of about six months' duration. His illness had begun with a kind of fugue. He had wandered away for three days and had "come to himself" in a neighbouring town, having no recollection whatever of what he had been doing or where he had been since leaving his home. His other symptoms were largely secondary to this. He was thoroughly frightened; he thought something awful was wrong with him and he dreaded a recurrence of this fugue. He attended the clinic almost every week for four months. No evidence of organic disease was found. The following facts were gradually brought out in conversation with him: He was a married man with four children; he had to support his mother in addition. His income was two hundred pounds per annum. He had a good war record. He had married during the war and his wife was of a rather superior type. It was something of a come-down when he returned to civilian life. Soon afterwards, however, he had an opportunity of a post abroad, which, although less secure than that which he held, had much more attractive prospects. He was a believer in "safety first," and he stayed on where he was. Shortly before his illness began he learned that the man who had taken this post abroad in his stead was now earning two thousand pounds per annum, and was in an excellent position.

Picture to yourselves the situation. Here is a man supporting a large family on two hundred pounds per annum, married to a woman with strong ideas of social uplift, who casts up to him what he might have been, by continually referring to the success of the other man, in a job which might have been his own. He feels inferior, wretched and sick of the whole thing. He sees no way out; an escape reaction of some sort is clearly indicated.

This at any rate was the explanation gradually put to the patient. It was all discussed very fully with him. He was told that his wandering off represented a strong wish to escape. He was told that he could not bring himself to appreciate that he had such a wish, because of his very conscientious nature. Taking advantage

of his war service, it was put to him that his case was similar to many that were then called "shell-shock." This put the whole thing on an intelligible basis to the man. He no longer felt that he had some mysterious disease; he was beginning to understand himself. He fully appreciated that his other symptoms were secondary to the major thing. This took about two months to explain. The remaining two months were spent in going over the ground again, and discussing in a simple way the principles of character formation in the way outlined by McDougall. In the early stages of treatment he was not allowed to be at work. He was told how to fill in his time by suitable occupations at home and in the garden, and he was given bromides for his insomnia. For the last month or so of treatment he was sent back to light work by arrangement with his employers. He is now well and free from symptoms. We are not concerned with whether the explanation offered to the patient is the true one or not. That mechanism at least played a part in his breakdown, superficial though it was. The fact is that the man regained his mental health, and that is the criterion we go by in assessing utility.

Social Service.

Social service is not only essential for the accurate collecting of facts, but it has definite therapeutic value, the two functions often going hand in hand, as the following case will show.

A boy, æt. 7, was referred to the clinic by the surgical unit, whither he had been sent because he complained of his "back passage being stopped up," and because he would go as long as a week without a motion. No organic lesion had been found. He was a miserable-looking child, nervous, pale, ill-kempt. His mother stated that he had been the victim of a homosexual assault some six weeks previously and had been in this condition ever since. He had changed from a bright, cheerful little fellow into a nervous, wretched object. He could not sleep at night, he could not do his lessons, and he was terrified of anyone coming into the house. His assailant was at this time awaiting trial at the Assizes.

Social service investigated this case and found that the patient's mother was a woman of the streets; his father was at home dying of cancer. The family was of the lowest grade and lived in a wretched locality. The mother, being both ignorant and in desperate financial straits, had a definite idea that in some mysterious

way she would get compensation when the case came up for trial. It was established beyond reasonable doubt that practically every one of the child's symptoms had been suggested to him by his mother. She was trying to make the child as ill as possible so that she could display him in court the better to press her case.

The mother and child were then brought back to the clinic. The child was reassured and was sent off to a rest home at the seaside for seventeen days, where he would mix with others of his own age convalescing from general hospital wards. The mother was told pretty straightly how things stood, and what effect her own behaviour was having on the child. I saw the child a short time after his return, and he was absolutely well in every way. Social service continues to keep track of this case, and will report should further action be required. As is often the case in these behaviour problems, half the treatment is to get the parents to adopt a proper attitude to the patient.

I have quoted only two cases to illustrate the methods we employ. We have many that do not progress to such a successful issue, but on the other hand, although we cannot free them of their symptoms, we can help them to such an extent that they are enabled to keep going and prevented from drifting. I do not consider that we can, except in a very few instances, arrest the development of the true psychoses, which require mental hospital care. That problem belongs, I dare to hope, more to the fields of child guidance and mental hygiene. The out-patient clinic is primarily a utility organization, serving the needs of that vast mass of indeterminate sort of people whose lives are a tangle, who drag on, not understanding themselves, mentally ill, yet not ill enough for mental hospital care, hitherto practically unprovided for, and almost without exception deeply appreciative of what is done for them.

It remains only to summarize the utility functions of the psychiatric clinic :

(1) It brings psychiatry and general medicine closer together.

(2) It provides unparalleled clinical experience for students if they care to attend it—for this is the sort of thing they are going to come across in general practice.

(3) It establishes closer relationship between mental hospital patients and their physicians by paving the way for their admission and by providing a follow-up or after-care service.

(4) It provides a consulting service for all classes, and in

this respect, particularly with difficult relatives, it is a great help to the general practitioner.

(5) It provides treatment for cases not ill enough to justify their admission to a mental hospital, and yet who will not recover without some form of treatment.

(6) It paves the way for enlightenment of the lay mind on the subject of mental illness.

In conclusion I must apologize for being didactic. It is necessary to be so in a short paper of this kind, and I thank you for bearing with me.

References.—(1) *Journ. Ment. Sci.*, April, 1926, lxxii, p. 171.—(2) Skottowe, Ian, "On the Methods in Vogue at the Boston Psychopathic Hospital," *Journ. Ment. Sci.*, July, 1928, lxxiv, p. 474.